

Humanitarian and Development Nexus for Health and Sexual and Reproductive Health

Briefing paper
May 2019

I. Summary

Strengthening the humanitarian-development divide was identified as a top priority at the 2016 World Humanitarian Summit, given the protracted nature of crises and limited development to sustain gains and maintain peace.¹ The *New Way of Working* has emerged as a framework towards achieving collective outcomes that reduce need, risk, and vulnerability over time based on the comparative advantage of the many actors that work in the humanitarian-development continuum.² Emergency preparedness and recovery—including for health and sexual and reproductive health—are two entry points within the crisis continuum that provide opportunities for humanitarian and development actors to explicitly collaborate with communities, civil society organizations, and governments, to build local and national resilience to mitigate impact, improve response, and facilitate effective recovery.

II. Background

The volume, cost, and length of humanitarian assistance over the past decade has grown dramatically, primarily due to the protracted nature of crises and limited development activities in many humanitarian contexts. Inter-agency humanitarian appeals last an average of seven years, and the size of appeals has increased nearly 400 percent in the last decade.³ This trend has elevated the long-standing discussion around better linkages between humanitarian and development efforts.

Simultaneous to the renewed appreciation to bridge the humanitarian-development divide, global policy developments not only acknowledge the need to meet needs, but to also reduce risks and vulnerability that contribute to cyclic and protracted crises. The *2030 Agenda for Sustainable Development* and *Sustainable Development Goals* (SDGs) provide a framework for humanitarian and

¹ One Humanity Shared Responsibility: Report of the United Nations Secretary-General for the World Humanitarian Summit (New York. 2016). Available from <https://sgreport.worldhumanitariansummit.org/>.

² OCHA Policy Development and Studies Branch. *The New Way of Working* (Geneva. 2017). Available from <https://www.unocha.org/es/themes/humanitarian-development-nexus>.

³ Inter-agency appeal funding requirements have increased from US\$4.8 billion in 2006 to \$19.7 billion in 2016. World Humanitarian Data and Trends 2016, OCHA, December 2016.

development actors to contribute to a common vision of “Reach the Furthest First” and “Leave No One Behind”.⁴⁵

Strengthening the humanitarian-development divide was identified as a top priority at the 2016 World Humanitarian Summit (WHS), including by donors, non-governmental organizations (NGOs), crisis-affected States, and others. As outlined in the *Secretary-General’s Report for the WHS* and the *Agenda for Humanity*, the *New Way of Working* emerged as a framework towards achieving collective outcomes that reduce need, risk, and vulnerability over multiple years, based on the comparative advantage of diverse actors that work in the humanitarian-development continuum.^{6 7 8} The notion of “collective outcomes” has been placed at the center of the WHS *Commitment to Action* that was signed by the Secretary-General, nine United Nations (UN) Principals, and endorsed by the World Bank and the International Organization for Migration.⁹

Ever since, the “triple nexus”—the nexus between humanitarian, development, and, when appropriate, peace—has been considered in the context of UN reform. This is emphasized in the 2016 resolutions on the review of the peacebuilding architecture: General Assembly Resolution 70/262 and Security Council Resolution 2282, as well as the 2018 *Report of the Secretary-General on peacebuilding and sustaining peace*.¹⁰ Governments and NGOs have further examined ways in which they can play a role in facilitating this dialogue, including the European Union and the International Council of Voluntary Agencies.^{11 12}

III. Addressing the humanitarian and development nexus

The key concepts of the *New Way of Working* include:¹³

- **Collective outcome:** A commonly agreed measurable result or impact (over 3-5 years) that reduces people’s needs, risks, and vulnerabilities and increases their resilience, requiring the combined effort of different actors. Proposed outcomes should be concrete and measurable and represent a middle ground between the current level of need, risk, and vulnerability, and the targets set by the SDGs.
- **Comparative advantage:** The unique, demonstrated capacity and expertise (not limited solely to a mandate) of one individual, group, or institution to meet needs and contribute to risk and vulnerability reduction, over the capacity of another actor.
- **Multi-year timeframe:** Analyzing, strategizing, planning, and financing operations that build over several years to achieve context-specific and, at times, dynamic targets.

The *New Way of Working* recognizes that greater collaboration, coordination, and coherence between humanitarian and development actors must be done in a way that respects humanitarian principles. While joint analysis should be undertaken, the *New Way of Working* acknowledges that in complex

⁴ United Nations Office for the Coordination of Humanitarian Affairs. *Agenda for Humanity* (New York. 2016). Available from <https://agendaforhumanity.org/>.

⁵ United Nations, *Sustainable Development Goals: 17 Goals to Transform our World* (New York. 2015). <http://www.un.org/sustainabledevelopment/sustainable-development-goals/>.

⁶ *One Humanity Shared Responsibility: Report of the United Nations Secretary-General for the World Humanitarian Summit* (New York. 2016). Available from <https://sgreport.worldhumanitarian summit.org/>.

⁷ United Nations Office for the Coordination of Humanitarian Affairs. *Agenda for Humanity* (New York. 2016). Available from <https://agendaforhumanity.org/>.

⁸ OCHA Policy Development and Studies Branch. *The New Way of Working* (Geneva. 2017). Available from <https://www.unocha.org/es/themes/humanitarian-development-nexus>.

⁹ Signed by FAO, OCHA, UNCHR, UNDP, UNFPA, UNICEF, WFP, WHO; IOM; co-signed by former UN Secretary-General Ban Ki-Moon and endorsed by World Bank President Jim Yong Kim. *World Humanitarian Summit Commitment to Action*. 2016. Available from <https://www.agendaforhumanity.org/initiatives/3837>.

¹⁰ *Peacebuilding and sustaining peace: Report of the Secretary-General. A/72/707–S/2018/43*.

¹¹ European Commission. *Resilience building and Humanitarian-Development Nexus*. Last accessed 5 May 2019. Available from: https://ec.europa.eu/europeaid/policies/fragility-and-crisis-management/resilience-building-humanitarian-development-nexus_en.

¹² International Council of Voluntary Agencies. *Demystifying the Humanitarian, Development and Peace Nexus*. Last accessed 5 May 2019. Available from: <https://www.icvanetwork.org/demystifying-nexus>.

¹³ OCHA Policy Development and Studies Branch. *The New Way of Working* (Geneva. 2017). Available from <https://www.unocha.org/es/themes/humanitarian-development-nexus>.

emergencies, separate humanitarian plans or coordination structures may be necessary to provide life-saving services. Despite this reality, the *New Way of Working* recommends humanitarian actors to increasingly engage with development partners to leverage each other's comparative advantages and facilitate a smooth transition between humanitarian and development efforts.¹⁴

IV. Nexus with Health

The World Health Organization (WHO) has developed a framework to bridge the humanitarian-development divide in health, based on the *New Way of Working*. The *New Way of Working* calls for a **shared analysis** and vision based on a robust evidence-base, and **joint planning** between health systems strengthening and humanitarian interventions. It also points to the need to identify **collective outcomes** from the onset of a crisis and a system to track short, medium, and long-term health outcomes. Image 1 developed by the WHO visualizes this framework.¹⁵

Humanitarian interventions should further focus on integration and transition to local authorities as early as feasible, through a cluster transition plan. Development-oriented workstreams should also target fragile and conflict-affected areas in a more operational manner.¹⁶

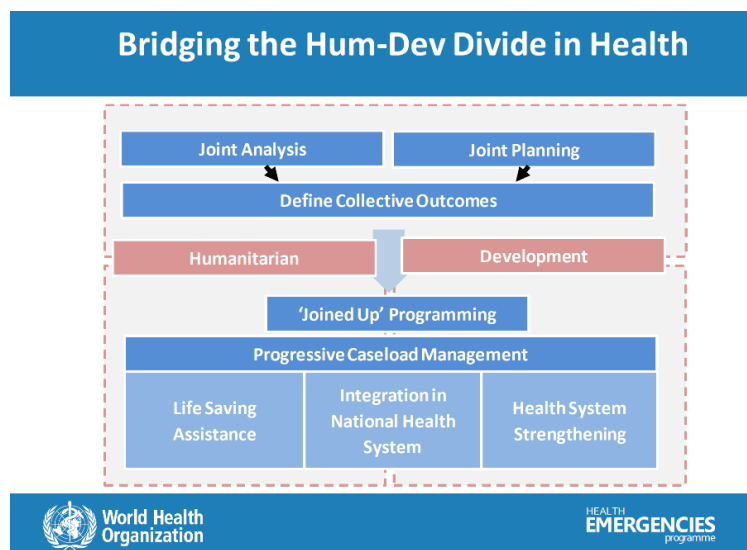
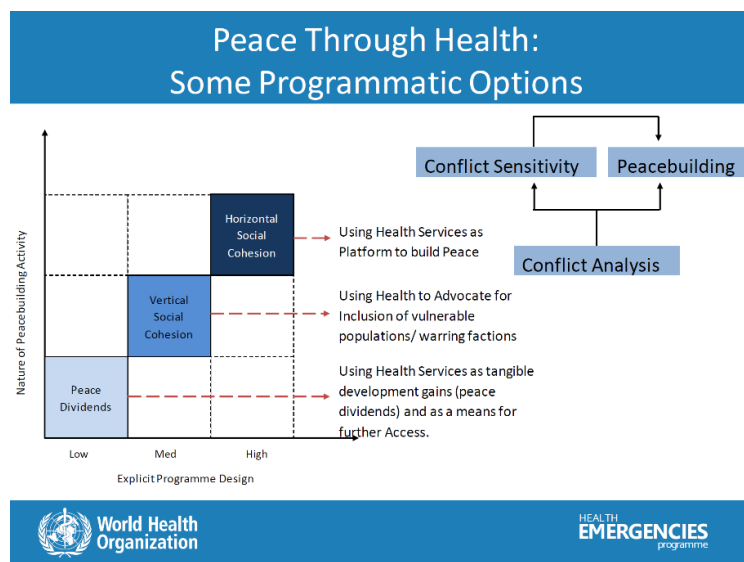


Image 1: Operationalizing the *New Way of Working* in health.



In terms of sustaining peace through health, it is important to consider whether health services are conflict-sensitive and whether health interventions can contribute to building peace. Programmatic options include considering health services as tangible development gains and to further access; using health to advocate for inclusion of at-risk or marginalized populations; and using health services as a platform to sustain peace. This approach is further visualized in Image 2 from the WHO.¹⁷

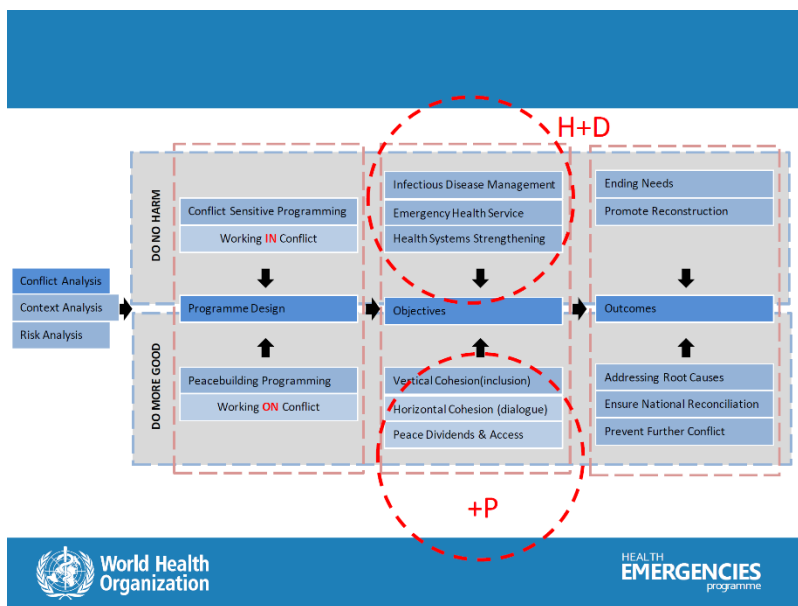
Image 2: Achieving peace through health.

¹⁴ OCHA Policy Development and Studies Branch. The New Way of Working (Geneva. 2017). Available from <https://www.unocha.org/es/themes/humanitarian-development-nexus>.

¹⁵ World Health Organization Health Emergencies Programme. The New Way of Working: Strengthening the Humanitarian, Development, Peace Nexus. Available from <https://www.who.int/health-cluster/about/structure/new-way-working.pdf>.

¹⁶ World Health Organization Health Emergencies Programme. The New Way of Working: Strengthening the Humanitarian, Development, Peace Nexus. Available from <https://www.who.int/health-cluster/about/structure/new-way-working.pdf>.

¹⁷ World Health Organization Health Emergencies Programme. The New Way of Working: Strengthening the Humanitarian, Development, Peace Nexus. Available from <https://www.who.int/health-cluster/about/structure/new-way-working.pdf>.



Putting this altogether, programmatic objectives can incorporate the humanitarian, development, and peace “triple nexus,” with interventions addressing immediate humanitarian need and strengthening health systems, through inclusive approaches (Image 3).¹⁸

Image 3: Putting this altogether.

V. Emergency and disaster risk management for health

While discussions to bridge the humanitarian-development divide and foster peacebuilding in fragile states have been underway, policy dialogue has also focused on mitigating the risks of disasters in particular, through risk reduction approaches. For the past decade, the UN International Strategy for Disaster Reduction’s (UNISDR) *Hyogo Framework for Action 2005-2015: Building the Resilience of Nations and Communities to Disasters* guided global dialogue and encouraged international and national stakeholders to invest in approaches that build community and country capacities to prevent, mitigate the impact of, and prepare for emergencies.¹⁹ In March 2015, the *Sendai Framework for Disaster Risk Reduction 2015-2030* was adopted by member states at the UN World Conference on Disaster Risk Reduction in Sendai, Japan. The framework calls for increased attention to resilience and identifies health as a critical aspect of strengthening individual and community resilience.²⁰

A multisectoral and multidisciplinary emergency and disaster risk management for health (EDRM-H) system protects public health and reduces morbidity, mortality, and disability associated with emergencies through effective prevention, preparedness, response, and recovery measures.²¹ While traditionally, the health sector has focused on emergency response, a more proactive approach can better build community and country capacities to prevent emergencies and enhance preparedness for a timely and effective response. This is further affirmed in the *Sendai Framework’s* Priority 3 to invest in disaster risk reduction:

“Enhance the resilience of national health systems, including by *integrating disaster risk management into primary, secondary and tertiary health care, especially at the local level; developing the capacity of health workers in understanding disaster risk and applying and implementing disaster risk reduction approaches in health work; promoting and enhancing the training capacities in the field of disaster medicine; and supporting and training community health*

¹⁸ World Health Organization Health Emergencies Programme. The New Way of Working: Strengthening the Humanitarian, Development, Peace Nexus. Available from <https://www.who.int/health-cluster/about/structure/new-way-working.pdf>.

¹⁹ United Nations Office for Disaster Risk Reduction, *Hyogo Framework for Action: Building the resilience of nations and communities to disaster* (Geneva, 2007). <https://www.unisdr.org/we/inform/publications/1037>.

²⁰ United Nations Office for Disaster Risk Reduction, *Sendai Framework for Disaster Risk Reduction 2015- 2030* (Geneva, 2015). <http://www.unisdr.org/we/coordinate/sendai-framework>.

²¹ Towards a post-2015 framework for disaster risk reduction. Geneva, United Nations International Strategy for Disaster Reduction, 2012 (http://www.unisdr.org/files/25129_towardsapost2015frameworkfordisaste.pdf).

groups in disaster risk reduction approaches in health programmes, in collaboration with other sectors, as well as in the implementation of the International Health Regulations (2005) of the WHO.²²

VI. Nexus for health in conflicts and disasters

Thus, based on dialogue and developments that address both recovery from crises and preparedness to mitigate future risks in the continuum of emergencies, WHO has developed strategic objectives to address the nexus—humanitarian and development, and conflict and disasters. These include:²³

- Progressively expanding access, coverage, and quality of an Essential Package of Health Services (EPHS).
- Progressively shifting from a focus on service delivery through support to health facilities, to area- and population-based approaches that support District Health Management (DHM) and engage communities.
- Conducting hazard emergency risk management.

WHO lists select activities that promote these objectives, including:²⁴

- Addressing early recovery, using the EPHS as a practical bridge.
- Conducting humanitarian needs/risk analyses, health sector reviews, and disaster risk assessments.
- Holding joint coordination meetings with humanitarian and development partners/International Health Partnership+, with complementarity in planning and funding.
- Establishing an Early Warning, Alert and Response Network (EWARN) for preparedness, applying International Health Regulations, and promoting EDRM-H.
- “Building back better” and improving resilience in recovery planning, as well as planning for health system resilience in National Health Strategic Plans.
- Making connections with the Global Fund for AIDS, TB, and Malaria, as well as Gavi, the global vaccine alliance.
- Piloting different provider payment mechanisms.
- Doing no harm and maintaining humanitarian principles.
- Remaining impartial in dialogue with governments.

VII. Implications for Sexual and Reproductive Health

In emergency situations where demands on health services are high and time and resources are limited, sexual and reproductive health (SRH) services are prioritized on the basis of saving lives, optimizing scarce resources, and responding to needs. Since 1997, the Minimum Initial Service Package (MISP) for reproductive health has been the standard of care for SRH interventions in humanitarian settings. The standard was recently updated in 2018 and encompasses the following objectives:²⁵

1. Ensure the health sector/cluster identifies an organization to lead implementation of the MISP.
2. Prevent sexual violence and respond to the needs of survivors.
3. Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs.

²² United Nations Office for Disaster Risk Reduction, Sendai Framework for Disaster Risk Reduction 2015-2030 (Geneva, 2015). <http://www.unisdr.org/we/coordinate/sendai-framework>.

²³ World Health Organization Health Emergencies Programme. The New Way of Working: Strengthening the Humanitarian, Development, Peace Nexus. Available from <https://www.who.int/health-cluster/about/structure/new-way-working.pdf>.

²⁴ World Health Organization Health Emergencies Programme. The New Way of Working: Strengthening the Humanitarian, Development, Peace Nexus. Available from <https://www.who.int/health-cluster/about/structure/new-way-working.pdf>.

²⁵ Inter-agency Working Group on Reproductive Health in Crises. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* (New York, 2019).

4. Prevent excess maternal and newborn morbidity and mortality.
5. Prevent unintended pregnancies.
6. Plan for comprehensive SRH services, integrated into primary health care as soon as possible. Work with the health sector/cluster partners to address the six health system building blocks.

a. Policy Framework for SRH

The 2016 WHS mobilized commitments related to women and girls, including gender-responsive programming, gender-based violence prevention and response, SRH, and women's involvement in mediation and peace processes.²⁶ The *Sendai Framework* was also a landmark development for SRH, as it identified SRH as a critical aspect of health and individual and community resilience.²⁷ Priority 3 on investing in disaster risk reduction calls for:

*“Strengthen the design and implementation of inclusive policies and social safety-net mechanisms, including through community involvement, integrated with livelihood enhancement programmes, and access to basic health care services, including **maternal, newborn and child health, sexual and reproductive health**, food security and nutrition, housing and education towards the eradication of poverty, to find durable solutions in the post disaster phase and to empower and assist people disproportionately affected by disasters.”²⁸*

The UN Secretary General's *Global Strategy for Women's, Children's and Adolescents' Health* (2016-2030), which aims to transform societies for women, children, and adolescents everywhere, includes preparedness as essential to building health system resilience. Preparedness also intersects with SRH in the *Global Strategy's* action areas for humanitarian assistance.²⁹ The SDGs additionally highlight the need to reduce SRH-related morbidity and mortality and ensure access to SRH services under Goal 3, as well as eliminate violence against women and girls under Goal 5. Goal 3 similarly includes the importance of EDRM-H to building health-system resilience.³⁰ All of these frameworks provide a facilitative environment to address SRH in recovery and preparedness, and the humanitarian-development nexus.

Recent disasters have given rise to many lessons around humanitarian response, including the promise that preparedness can have for timely and appropriate SRH interventions during crises.³¹ Learning shows that communities can and should be more involved in emergency response; civil society groups need to understand the humanitarian system to access it; communities must be better informed of available services; and SRH services available before a crisis are more likely to be available after the crisis.³²

To date, numerous efforts have been undertaken at global, regional, district, and community levels to address SRH in preparedness efforts. An RH working group has been created within the UNISDR Thematic Platform for EDRM-H, which has developed a policy brief (currently under revision),³³ fact

²⁶ World Humanitarian Summit. Commitments to Action Report 2016, World Humanitarian Summit Istanbul 23-24 May 2016. Available at:

https://www.agendaforhumanity.org/sites/default/files/resources/2017/Jul/WH_Summit_Commitment_to_Action_8September2016.pdf.

²⁷ United Nations Office for Disaster Risk Reduction, *Sendai Framework for Disaster Risk Reduction 2015-2030* (Geneva, 2015). <http://www.unisdr.org/we/coordinate/sendai-framework>.

²⁸ United Nations Office for Disaster Risk Reduction, *Sendai Framework for Disaster Risk Reduction 2015-2030* (Geneva, 2015). <http://www.unisdr.org/we/coordinate/sendai-framework>.

²⁹ United Nations, *Every Woman Every Child, The Global Strategy for Women's, Children's and Adolescents' Health* (2016-2030): Survive, Thrive, Transform (New York, 2015).

http://globalstrategy.everywomaneverychild.org/pdf/EWEC_globalstrategyreport_200915_FINAL_WEB.pdf.

³⁰ United Nations, *Sustainable Development Goals: 17 Goals to Transform our World* (New York, 2015).

<http://www.un.org/sustainabledevelopment/sustainable-development-goals/>.

³¹ Krause, S. et al, *Sea-change in reproductive health in emergencies: how systemic improvements to address the MISP were achieved. RH Matters* 2017.

³² Tanabe, M. *Building National Resilience for SRH: Learning from Current Experiences*. New York: WRC, 2016.

³³ World Health Organization, *Integrating sexual and reproductive health into health emergency and disaster risk management* (Geneva, 2012). http://www.who.int/hac/techguidance/preparedness/SRH_HERM_Policy_brief_A4.pdf?ua=1.

sheet,³⁴ and tool³⁵ to guide SRH integration in EDRM-H at the national level. The Inter-agency Working Group (IAWG) on RH in Crises' Eastern European and Central Asia region further developed a "MISP Readiness Assessment tool" in 2013 to assess the extent to which countries within the region were ready to develop and implement an adequate SRH response in emergencies. The UN Population Fund (UNFPA) Philippines and the Women's Refugee Commission additionally developed a community-based curriculum, *Facilitator's Kit: Community Preparedness for Reproductive Health and Gender*, a three-day training to build capacity at the community level to prepare for and respond to risks and inequities faced by women and girls during emergencies.³⁶ With the revision of the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* in 2018, the IAWG has further developed a workshop toolkit to transition from emergency response to more comprehensive SRH programming.³⁷

At the same time, field experience has shown that Objective 6 of the MISP remains challenging to implement, as it requires vision, leadership, effective coordination skills, and a sound understanding of the local situation and opportunities related to health system reconstruction.³⁸ The transition from the MISP to comprehensive SRH has thus been marred with challenges similar to facilitating coordinated and effective recovery.³⁹

³⁴ World Health Organization, Disaster Risk Management for Health Fact Sheets: Sexual and Reproductive Health (Geneva. 2011). http://www.who.int/hac/events/drm_fact_sheet_sexual_and_reproductive_health.pdf

³⁵ United Nations Office for Disaster Risk Reduction, Integrating Sexual and Reproductive Health (SRH) into Emergency and Disaster Risk Management for Health: Building resilient communities and reproductive health systems: National Monitoring Tool,(Geneva. DRAFT).

³⁶ Women's Refugee Commission and UNFPA, Community Preparedness: Reproductive Health and Gender: A Facilitator's Kit for a 3-day Training Curriculum (New York. 2015).

³⁷ Inter-agency Working Group on Reproductive Health in Crises. Integrating sexual and reproductive health into health system reconstruction: A workshop toolkit to catalyze participatory planning to move from the Minimum Initial Service Package (MISP) for Sexual and Reproductive in Crisis Situations to comprehensive sexual and reproductive health programming (New York. 2018).

³⁸ Inter-agency Working Group on Reproductive Health in Crises. Integrating sexual and reproductive health into health system reconstruction: A workshop toolkit to catalyze participatory planning to move from the Minimum Initial Service Package (MISP) for Sexual and Reproductive in Crisis Situations to comprehensive sexual and reproductive health programming (New York. 2018).

³⁹ Casey SE, Chynoweth SK, Cornier N, Gallagher MC, Wheeler EE. Progress and gaps in reproductive health services in three humanitarian settings: mixed-methods case studies. *Confl Health*. 2015; 9: S3.

b. MISP to comprehensive SRH

The MISP was designed to form the starting point for SRH programming at the onset of an emergency. As highlighted in Objective 6, the clinical services of the MISP should be sustained, improved in quality, and expanded upon with other comprehensive SRH services and programming throughout protracted crises, recovery, and reconstruction. The IAWG conceptualizes the emergency continuum in the context of SRH as visualized in Image 4.⁴⁰

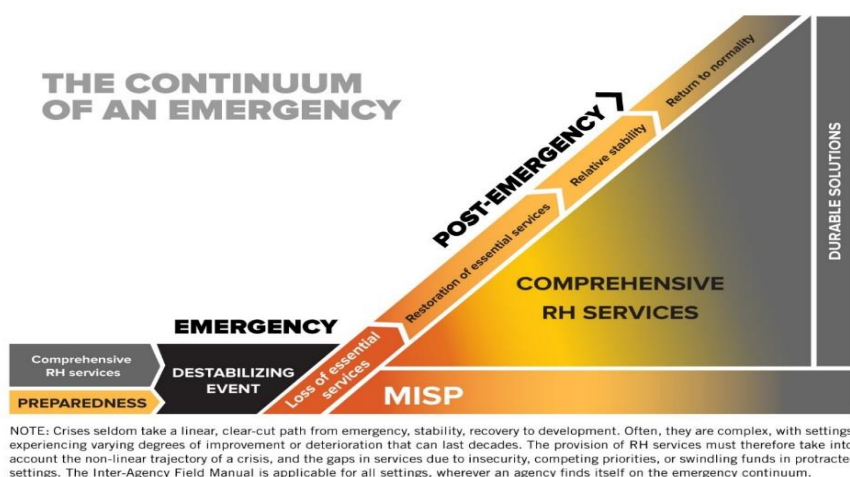


Image 4: Emergency continuum, per the IAFM

Priorities for achieving comprehensive SRH should include the broadening and strengthening of MISP services, as well as the inclusion of SRH services that fall outside of the MISP. According to a report from the Guttmacher-Lancet Commission, comprehensive SRH services are, “Essential SRH services that must meet public health and human rights standards, including the ‘Availability, Accessibility, Acceptability, and Quality’ framework of the right to health. The services should include:

- accurate information and counselling on SRH, including evidence-based, comprehensive sexuality education;
- information, counselling, and care related to sexual function and satisfaction;
- prevention, detection, and management of sexual and gender-based violence and coercion;
- a choice of safe and effective contraceptive methods;
- safe and effective antenatal, childbirth, and postnatal care;
- safe and effective abortion services and care, to the full extent of the law;
- prevention, management, and treatment of infertility;
- prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections; and
- prevention, detection, and treatment of reproductive cancers.”⁴¹

Areas to consider in the transition include: Communication among decision-makers (including national governments) and implementing partners; adequate financing; effective coordination; supply chain management; human resources management; monitoring and evaluation; system of information sharing, feedback, and accountability to the affected community; and development of an exit strategy

⁴⁰ Inter-agency Working Group on Reproductive Health in Crises. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* (New York, 2019).

⁴¹ Accelerate progress—sexual and reproductive health and rights for all: Report of the Guttmacher–Lancet Commission, May 2018. Available from <https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights>.

for humanitarian partners.⁴² These align with the WHO’s Health System Building Blocks (see Table 1):⁴³

Table 1: Health System Building Blocks and SRH⁴⁴

Health systems building block	When planning for comprehensive SRH services, collaborate with all stakeholders to:
Service delivery	<ul style="list-style-type: none"> • Identify SRH needs in the community. • Identify suitable sites for SRH service delivery.
Health workforce	<ul style="list-style-type: none"> • Assess staff capacity. • Identify staffing needs and levels. • Design and plan staff training.
Health information system	<ul style="list-style-type: none"> • Include SRH information in the health information system.
Medical commodities	<ul style="list-style-type: none"> • Identify SRH commodity needs. • Strengthen SRH commodity supply lines.
Financing	<ul style="list-style-type: none"> • Identify SRH financing possibilities.
Governance and leadership	<ul style="list-style-type: none"> • Review SRH-related laws, policies, protocols. <ul style="list-style-type: none"> • Coordinate with MOH. • Engage communities in accountability.

The IAWG on RH in Crises has developed a toolkit to facilitate the transition from the MISP to comprehensive SRH services, with a focus on participatory planning. The toolkit guides SRH coordinators in facilitating a national (provincial or sub-provincial) workshop to catalyze participatory planning among national stakeholders and partners to improve the quality of MISP services and integrate comprehensive SRH services into national health system reconstruction efforts through a collective work plan.

As with the MISP, comprehensive SRH services must be accessible for all crisis-affected populations, including adolescents; unmarried as well as married women and men; persons with disabilities; and lesbian, gay, bisexual, queer, questioning, intersex, and asexual (LGBTQIA) persons. Comprehensive SRH services should be designed to be inclusive and meet the needs of often marginalized populations.⁴⁵

c. SRH in preparedness efforts

Achieving comprehensive SRH can further help “build back better,” to support preparedness and resilience efforts. The development and implementation of health emergency response plans as part of preparedness efforts should actively engage communities, to ensure prompt MISP implementation

⁴² Inter-agency Working Group on Reproductive Health in Crises. “Minimum Initial Service Package for Reproductive Health.” *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* (New York. 2019).

⁴³ Inter-agency Working Group on Reproductive Health in Crises. Integrating sexual and reproductive health into health system reconstruction: A workshop toolkit to catalyze participatory planning to move from the Minimum Initial Service Package (MISP) for Sexual and Reproductive in Crisis Situations to comprehensive sexual and reproductive health programming (New York. 2018).

⁴⁴ Inter-agency Working Group on Reproductive Health in Crises. “Minimum Initial Service Package for Reproductive Health.” *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* (New York. 2019).

⁴⁵ Inter-agency Working Group on Reproductive Health in Crises. Integrating sexual and reproductive health into health system reconstruction: A workshop toolkit to catalyze participatory planning to move from the Minimum Initial Service Package (MISP) for Sexual and Reproductive in Crisis Situations to comprehensive sexual and reproductive health programming (New York. 2018).

when emergencies occur, and a smoother transition to comprehensive SRH. Efforts to strengthen EDRM-H, including SRH services, require a sustained investment of resources for building capacities and delivering services to meet the varying needs of at-risk groups. The following recommendations are intended for various stakeholders to effectively integrate SRH into EDRM-H at all levels:

Global level

- **Promote implementation** of the *Sendai Framework* and other policies that facilitate the integration of SRH into EDRM-H efforts at all levels, emphasizing coordination, the importance of building resilient primary health care systems, and ensuring inclusion and participation of at-risk groups.
- **Finance resilient health systems**, inclusive for SRH. Donors are responsible for ensuring sustainable SRH integration into EDRM-H efforts through efforts to provide funding for the entire disaster management cycle.

Regional level

- **Enhance regional partnerships and accountability** for SRH integration into EDRM-H efforts. Processes such as the MISP readiness tool can help identify gaps in SRH preparedness, provide opportunities for action planning, designate roles and responsibilities, foster government buy-in, and create a forum for communication and coordination.

National level

- **Incorporate SRH into multisectoral EDRM-H policies and plans** at national, subnational, and district levels. Allocate human and financial resources to integrate SRH into national plans of action for risk reduction (including preparedness) and in emergency response and recovery plans. Ensure SRH services are part of national health policies and stable primary health care systems, to build resilience and capacity.
- **Take an intersectoral, multisectoral, or team approach** to establish strong coordination among national, subnational, and district efforts, and engage all relevant sectors and stakeholders, including SRH actors, disaster management agencies, line ministries, UN agencies, NGOs, the Red Cross movement, and other civil society actors. An RH working group should be established with a formalized terms of reference within the official EDRM-H system, based on realistic actions plans, achievable outcomes, and built-in accountability mechanisms. Subnational and district efforts should be embedded within the official EDRM-H system, feedback mechanisms should function across levels, and funding made available to support localized efforts.
- **Create an environment of learning and awareness.** Foster an awareness of key SRH risks and actions within a culture of improving community health, safety, and resilience at all levels. Include EDRM-H, including risk assessment, vulnerability reduction, emergency response planning, and the MISP in the curricula for midwives, nurses, public health workers, and the broader health emergency management community. Strengthen media advocacy on the importance of maintaining SRH services during a response.
- **Ensure a continuous monitoring and evaluation system** with regular follow-up to achieve sustainability of SRH integration into EDRM-H processes, and to evaluate SRH action responses against preparedness efforts at all levels.

District/community level

- **Integrate SRH into health risk assessments and provide early warning** for communities. Incorporate assessments of SRH risks, vulnerabilities, and capacities, informed by poverty, gender, and disability analyses. Estimate the impact of identified SRH risks (such as vulnerable populations, percentage of home deliveries, or access to vehicles for obstetric and newborn complications) to strengthen the overall primary health care system and plan for response.
- **Identify and reduce risks for vulnerable communities and SRH services.** Address underlying health vulnerabilities by ensuring strong primary health care and preventive health measures with

key provisions for SRH. Establish community networks to identify and monitor local vulnerabilities and capacities, build health facilities to withstand local hazards, and ensure that these facilities remain functional to provide SRH services, including care for childbirth and obstetric and newborn complications during emergencies.

- **Develop community action plans that prepare existing SRH services to absorb impact, adapt, respond to, and recover** from emergencies. Action plans should address inclusion of at-risk populations (women, adolescents, newborns, persons with disabilities, LGBTQIA, and other minorities) that reflect risk assessment, gender, and other analyses. Build capacity of critical stakeholders to implement the MISP, pre-position RH Kits, maintain vehicles for referrals, and clarify roles and responsibilities to ensure a comprehensive, well-coordinated response.
- **Actively involve at-risk groups**—including women, adolescents, persons with disabilities, LGBTQIA, and other minorities—and work with community stakeholders, such as health providers, youth groups, and women’s groups in all preparedness planning. Encourage community participation in RH working groups and cluster discussions and support their role as critical first responders in emergencies.

VIII. Conclusion

The **New Way of Working** offers a concrete and measurable path forward to bridge the humanitarian-development divide and reduce risks and vulnerabilities. Emergency preparedness and recovery are two entry points within the continuum of an emergency that provide an opportunity for humanitarian and development actors to explicitly collaborate with communities, civil society organizations, and governments, to build local and national resilience to mitigate the impact of emergencies, improve response, and facilitate efficient and effective recovery.